October 17, 2014

Secretary Sylvia Matthews Burwell
Department of Health and Human Services
330 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

On behalf of the over 29 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) provides the following comments and recommendations regarding Arkansas' Proposed Amendment to the Health Care Independence 1115 Waiver.

According to the Centers for Disease Control and Prevention, 215,000 adults in Arkansas have diabetes. Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid.[1] For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a recent study conducted in California found "amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state."[2] Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. As such, the Association strongly supports Arkansas's decision to accept federal Medicaid funding to extend eligibility for the program. We do, however, have concerns regarding some of the provisions in the Proposed Amendment to the Health Care Independence 1115 Waiver, and provide the following comments and recommendations to help ensure the needs of low-income individuals with diabetes are met by the state's Medicaid program.

The Proposed Cost-Sharing Requirements Will Deter Enrollment and Use of Services

The Association is concerned by the amount of cost-sharing and monthly contributions enrollees will be required to pay as outlined in Proposed Amendment to the Health Care Independence 1115 Waiver. In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of $10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.[3] In addition, a Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP

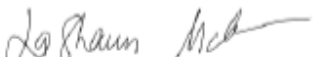
programs found that "[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes."[4] The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Under the Proposed Amendment to the Health Care Independence 1115 Waiver, Arkansas is proposing monthly contributions into an "Independence Account" ranging from $5 for those who have incomes between 50% and 100% of the Federal Poverty Level (FPL) to $25 for those earning between 129% and 133% of the FPL. Beneficiaries earning under 50% of the FPL will not be required to make monthly Independence Account contributions nor pay cost-sharing for services and supplies they receive under the program. For beneficiaries with incomes over 50% of the FPL, cost-sharing amounts consistent with Medicaid requirements will be paid from their Independence Accounts—to which the state will contribute funds in order to meet the beneficiary's cost-sharing obligations. Beneficiaries with incomes between 50% and 100% of the FPL who do not pay their monthly Independence Account contributions will be required to pay Medicaid-level copayments for the services and supplies they receive under the program. Beneficiaries with incomes over 100% of the FPL who do not pay their monthly contributions will be required to pay the cost-sharing requirements of their health plan.

The proposed monthly Independence Account contribution amounts are very likely to deter individuals from obtaining Medicaid coverage, negating the benefits of extending eligibility to the new adult group. In addition, while individuals who do not pay their monthly contributions are not disenrolled from the Medicaid program, they are faced with cost-sharing requirements which could deter them from seeking necessary medical care. The Proposed Amendment to the Health Care Independence 1115 Waiver notes that beneficiaries earning under 100% of the FPL cannot be denied medical services for not paying co-payments or co-insurance, however, individuals who do not have the funds in their Independence Accounts to cover the cost-sharing will "incur a debt to the state." For an individual with a complex, chronic illness requiring continuous medical care—such as diabetes—that potential debt to the state could become substantial. A Medicaid beneficiary faced with a co-payment he or she cannot afford is likely to forgo needed medical care rather than incur a debt to the state they are unable to pay.

Since the beginning of this year, Arkansas had the greatest drop in uninsurance rates in the country.[5] It would be a great disservice to Arkansas residents if these proposed changes undo the excellent work the state has done to ensure every resident of Arkansas has access to adequate, affordable health care. The Association wants this momentum to continue, but also wants to ensure all Medicaid beneficiaries in Arkansas—including those in the new adult eligibility group—are protected by the federal Medicaid rules. Federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150% FPL.[6] **Therefore, we recommend CMS ensure all cost-sharing for Arkansas Medicaid beneficiaries—including those enrolled in qualified health plans—continues to meet federal Medicaid rules.**

We appreciate the opportunity to provide comments on Arkansas' Proposed Amendment to the Health Care Independence 1115 Waiver. If you have any questions, please contact me at lmciver@diabetes.org or (703) 299-5528.

Sincerely,



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[1] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf
[2] Stevens CD, Schriger DL, Raffetto B, et. al, Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California, 8 Health Affairs 33, August 2014
[3] Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014
[4] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013
[5] Gallup-Healthways Well-Being Index, August 5, 2014, available at http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx.
[6] 42 C.F.R. § 447.52(e)(1) and § 447.55(a).